Accessing Mental Health Services for Newcomers in Alberta

Environmental Scan

Final Report

April 2017

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Acronyms & Abbreviations

AAISA	Alberta Association of Immigrant Serving Agencies
AHS	Alberta Health Services
BVOR	Blended Visa Office-Referred
GAR	Government Assisted Refugee
IRCC	Immigration, Refugees and Citizenship Canada
IRPA	Immigration and Refugee Protection Act
IOM	International Organization for Migration
ISP	Integrated Services Program
PHAC	Public Health Agency of Canada
PR	Permanent Resident
PSR	Privately Sponsored Refugee
PTSD	Post-Traumatic Stress Disorder
RAP	Resettlement Assistance Program
SAH	Sponsorship Agreement Holder
SPO	Service Provider Organization
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organization

I. About AAISA

The Alberta Association of Immigrant Serving Agencies (AAISA) is a regionally and nationally recognized leader in the settlement and integration sector. As an umbrella organization, AAISA's mandate is to build sectorial capacity by providing member agencies that serve newcomers access to relevant and meaningful professional development opportunities, to act as a liaison with stakeholders, and provide a centre for knowledge, expertise, and leadership. Our member agencies provide services to assist newcomers in becoming fully integrated members of Alberta society. Examples of services include orientation, interpretation, counselling, employment services, educational assistance, and programs for immigrant youth.

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III. Executive Summary

With the financial support of Immigration, Refugees and Citizenship Canada (IRCC), AAISA partnered with MMK Research and Consulting to conduct an environmental scan study of "Accessing Mental Health Services for Newcomers in Alberta." This study intends to assess the diversity of mental health resources, programs, and services available to newcomers and offer a breakdown of accessibility. The environmental scan will serve to better understand mental health and develop recommendations that will enable organizations to support newcomers as they successfully settle and integrate in communities across Alberta.

The results of this scan are based on a mixed-methods approach which involves a comprehensive review of literature, an online environmental scan of service providers and services, as well as 28 in-depth interviews and surveys with immigrants and service providers. Through this approach, key insights and recommendations were generated, which can serve to guide decision-making on newcomer mental health at both the policy and programmatic level. This report is intended to be a strategic resource for Resettlement Assistant Program (RAP) Providers, health providers, settlement and integration Service Provider Organizations (SPOs), Sponsorship Agreement Holders (SAHs), funders, public institutions, and community organizations.

Key Findings

One of the key observations from this study is on the broad conception of "mental health" by representatives of service providers, encompassing the wide spectrum from (positive) mental health or wellness, through mental health issues or 'mental conditions.' Because participants were drawn from a wide spectrum of organizations, the study details the great variability in terms of service provision. Alberta Health Services offers the most comprehensive health-related services in the province. There are also many agencies such as immigrant-serving agencies and ethno-cultural agencies, that provide specific mental health and counselling services to immigrants and refugees. However, there are some gaps in both the geographical distribution of centers, and in the levels and complexity of mental health service provision. There are also differences across cultures that make it challenging for providers to provide appropriate services that meet client needs in the absence of cultural competency skills and adequate resources.

The major themes that emerged in qualitative data were:

Cultural Relevance is cited as one of the biggest challenges to providing mental health services that meet the needs of refugees and immigrants. This challenge is related to a lack of knowledge of the nature and extent of trauma most clients have experienced before arriving in Canada. Defining the problem in a holistic way while considering root causes could help lead to appropriate referrals and supports.

Communication and Language Barriers was mentioned by all service providers, refugees and immigrants interviewed as one key roadblock to providing appropriate supports that meet newcomer mental health needs, even before concerns or worries develop into 'issues', or later into medical problems.

Other barriers to services includes the need for childcare provision, adequate transportation, and reducing wait times to access mental health professionals. The existence of stigma around mental health also makes it harder for people to accept that they have a problem that they need to get help for.

Capacity refers to both human and capital resources of an organization. Lack of specialized mental health professionals leads to a greater number of referrals and long wait times that can stall access to service provision. Coordination and collaboration challenges among providers negatively impacts the quality of referrals and prevents organizations from pooling resources when necessary.

Recommendations

There are several recommendations emanating from the study. These can be divided into:

Professionalization: Training for clinicians and para-professionals in cultural competency to allow for greater diversity and inclusion.

Holistic approach to mental health/illness treatment: Clinical diagnosis should be done under global approach where psycho-social therapy plays a role.

Systemic: A need for clear pathways to accessing mental health services; better coordination between service providers, policy makers and the clients.

Improved funding for agencies and other service providers.

There are very complex issues involving mental health in Alberta. A more in-depth study using bigger samples sizes would yield more generalizable results and further insights. The findings would be generalizable to other regions not covered by individual and organization interviews, and would provide a robust framework for policy makers and guidelines for service providers.

IV. Introduction

Background

In Canada, one in every three people will experience a mental health problem at some point in their lifetime. For members of various ethno-cultural communities, language and cultural differences make it especially difficult for people to seek out and find the mental health support they need. This is despite the fact that newcomers, including refugees, are particularly vulnerable to mental health illnesses: "separation from family, loss of support, language barriers, cultural adjustments and challenges in finding a home, work and community all contribute to stress and make a person more vulnerable to mental health issues."[1]

Promoting and protecting the mental health of immigrants and refugees by meeting their psychosocial needs allows them to attain enhanced well-being, which is an important part of their integration into a new country. "Healthy migrants are well-integrated migrants," recently stated the Director General of the International Organization for Migration.[2]

Since Canada is a diverse country, with millions of people from many backgrounds, and cultures and speaking more than 200 languages,[3] it can be challenging to provide mental health services and supports to such a diverse population.[4] Numerous studies across the country have noted huge gaps in service provision.[5]

In 2012, the Mental Health Commission of Canada's **Changing Directions, Changing Lives: The Mental Health Strategy for Canada**, identified Disparities and Diversity as one of the six priority strategies to address the specific needs of new Canadians. In-line with national health policy and the growing need for relevant mental health support and service provision for refugees and immigrants, AAISA initiated the "Accessing Mental Health Services in Alberta" research project to assess the diversity of services available to newcomers and offer a breakdown of accessibility.

Currently, existing mental health services in Canada are deemed ill-prepared to deal with immigrants and refugees with mental problems because of key challenges (e.g., language, culture, social isolation) and resettlement hurdles they face.[6] The Alberta Government (2015) has reported of gaps existing in the system with regard to adequate and appropriate addiction and mental health services for Albertans. The challenge then, is to find the best ways to make available and accessible mental health services to Alberta's diverse population.

This research, environmental scan and interviews, particularly the latter, exemplify the importance of involving direct users of mental health services. Newcomers have experiential knowledge of settlement challenges in Canada, and the attendant mental health problems. Their experiences and perspectives, complemented by the views and experiences of service providers, can greatly inform the planning of appropriate as well as improved services and methods of delivery informed by research-based evidence.

Rationale

AAISA's mandate is to build the capacity of organizations that work with newcomers and refugees in Alberta. Accordingly, AAISA proactively addressed the necessity for up-to-date research on the existing programs and services available to all refugees and newcomers through the Accessing Mental Health Services Environmental Scan. For the purpose of this study, an environmental scan is defined as a process that systematically surveys programs and services, and interprets relevant data to identify external needs and opportunities.

The assessment was conducted between January and March 2017. It is aimed to better understand the need for mental health services, the programs and services designed to support newcomer settlement and integration, and the corresponding organizational and system capacity in Alberta. For this reason, the primary focus of this research is to:

- Scan existing programs and services already in place to support mental health needs relevant to newcomers within the ambit of Alberta Health Services, Resettlement Assistance Programs (RAP), community health services, and language training, as well as other resettlement and support services; and
- Understand the existing mental health services as it pertains to newcomer specific needs: language, diversity and cultural competency as well as identify challenges and shortcomings to access;
- Generate evidence to guide decision-making and improve program and service planning.

As a strategic resource for a variety of stakeholders such RAP Providers, settlement and integration service providers, community organizations such as faith-based organizations, Sponsorship Agreement Holders, health providers, community members and funders, this report is designed to empower stakeholders with information that will guide decision-making on mental health policy and programming by:

- Improving mental health service planning as settlement and integration service provider organizations work to support preventative, holistic, and specific newcomer mental health needs; and
- Empowering policy makers to allocate funding and design institutional supports with the needs of newcomers in mind.

V. Approach and Methodology

Literature Review

The research team carried out a review of literature on mental health as it pertains to newcomers in Canada. The review of literature served as a basis for in-depth interviews and surveys with newcomers and service providers.

Inventory of Mental Health Programs and Services for Newcomers in Alberta

To understand the existing system capacity in Alberta to meet the mental health needs of newcomers and refugees, the research team created an inventory of programs of mental health programs and services across Alberta. Through internet research, the inventory gathered services and programs divided between Edmonton capital region and North Zone (including Fort McMurray and Grande Prairie) in **Appendix B**; Calgary Zone, Central Zone (including Red Deer), and South Zone (including Lethbridge and Medicine Hat) in **Appendix C**. A map of all AHS specific service locations can be found in **Appendix D.**

The inventory examined:

- Contact Information
- Mandate, mission & values
- Type and level of services provided (e.g., language services, counselling, mental health)
- Resources available (Human, financial)
- Clientele (Demographics: age, gender, ethnicity, region)
- Referrals (to and from)

Qualitative and quantitative approaches:

Qualitative data was collected using in-depth interviews (n=28) with immigrants and representatives of organizations which provide services to newcomers. Out of these interviews, nine immigrants – both refugee and non-refugee (n=9) immigrants – were recruited using convenience sampling and snowballing and then interviewed for in-depth qualitative data on their experiences accessing mental health resources and facilities. Nineteen (n=19) representatives from health and immigrant serving organizations in Alberta were interviewed which include Multicultural Health Brokers, Edmonton Mennonite Centre for Newcomers, Alberta Health Services, and Africa Centre, among others. (See **Appendix A: Services for Refugees and Immigrants** for list with corresponding Interviewee number)

Quantitative data was collected to show distribution and provision of services, and access by immigrants and refugees within the province. A brief survey was also conducted to determine how refugees and immigrants perceived access and quality of mental health services in the province.

VI. Literature Review

Why Mental Health?

Mental health and well-being are key to enabling human beings to function normally, enjoy life, and deal with daily challenges.[7] In general, good mental health is related to mental and psychological well-being.[8] If mental health and well-being are integral to our lives, enabling us to form and maintain relationships, to study, work or pursue leisure interests, make day-to-day decisions about employment, education, housing and many other things, it is logical to think that any disruption to one's mental health can significantly alter capacity to make decisions or choices about all these key aspects of our lives. According to the World Health Organization (WHO), any disturbance to one's mental well-being can lead to diminished functioning not only "...At the individual level, but also to broader welfare losses for the household and society."[9]

Alterations to one's mental health leads to mental disorders and 'diminished functioning'. It is reported that between 35-50% of people with severe mental disorders do not receive treatment in industrialized countries, and, those that receive treatment, it is of poor quality.[10] According to WHO, health systems in most countries have not responded well to the burden of mental disorders, resulting in gaps between the need for treatment and its provision.

Mental disorders frequently lead individuals and families into poverty.[11] Consequently, people with mental disorders often live in helpless situations and prone to exclusion and marginalization. With the absence of positive mental health, people experience mental health problems that can escalate to mental health disorders. Each year, one in every five Canadians experiences one or more mental health problems.[12] While this alone is a significant burden challenging individuals and their families, it also creates a significant cost to the health system.

Mental Health Definition

The WHO leads the way with regards to definitions and conceptualizations of all things related to health and well-being. In its key documents and constitution, the WHO articulates a positive dimension of mental health in its definition of health. According to the WHO, "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity", (our emphasis).[13] Hence 'mental health' is part of that sum called 'health'. A significant implication of this definition also is that mental health is more than just the absence of mental disorders or disabilities. It has a lot to do with our ability to carry out our daily functions, enjoy life, and deal with daily challenges. This makes mental health an integral part of one's overall health.

The WHO defines mental health as "...a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community."[14] The Public Health Agency of Canada (PHAC) has a similarly inspiring definition, pointing out the importance of everyone's "...ability to feel, think, and act in ways that enhance our ability to enjoy life and deal with the challenges we face...".[15] While PHAC's definition is used and referred to by many organizations, we deliberately chose WHO's definition because the key words used "...cope with the stresses of life" and "...can work productively and.....contribut[e]... to...[the]...community" resonate strongly with the experiences of immigrants and refugees.

The stresses of settling in a new country and coping with the day-to-day living significantly influence the lives of immigrants and refugees. For refugees, coping with past experiences of persecution in the countries they fled from is an added burden. For both immigrants and refugees, finding a job and being productive enough to feed their families and contribute to the wider community are key goals that are not easy to achieve in a new country. According to the WHO, mental health and well-being are key to our ability to "...earn a living and enjoy life..." While good mental health allows us to 'earn a living and enjoy life', failing to earn a living negatively impacts one's mental health, as has been widely reported in the literature.[16]

Why Immigrants and Refugees?

People migrate from their countries of origin for various reasons. For those that enter destination countries as immigrants, reasons include inequality and poor job prospects in their home countries, globalization, climate change, poverty, urbanization, and the search for a better future for themselves and their families.[17] Factors also include escape from political and economic systems deemed unsafe and a threat to livelihoods. But for those that enter destination countries as asylum seekers or refugees, reasons mainly include political and ethnic conflicts and persecution by home country governments.[18] People usually flee from war, famine, or human rights violations as a result of genuine fear of being persecuted for reasons of race, religion, nationality, membership in a particular social group, or political opinion.[19]

Between 2006 and 2011 alone, 1,162,900 foreign-born people immigrated to Canada.[20] While immigrants were predominantly from Europe and then Eastern Europe since confederation, immigration, particularly during the past five years, largely been from Asia (including the Middle East).[21] The share of immigration from Africa, Caribbean, Central and South America has also increased in the past ten years. Political conflicts in many parts of Eastern Europe and Africa has also fueled the tide of refugees to neighbouring countries and industrialized countries such as Canada.

In 2011, the majority of immigrants (94.8%) of Canada's foreign-born population lived in Ontario, British Columbia, Quebec and Alberta, in comparison to 83.7% of individuals born in Canada that the four provinces accounted for.[22] Also by 2011, 9.5% of the total number of foreign-born people lived in Alberta.[23] In 2011, the National Household Survey reported more than 200 ethnic origins in Canada.[24] Such an amount of immigration and refugee inflow from diverse countries with diverse cultures and languages other than English and French (the two official languages), is an important reason to reflect on the mental health services these immigrants and refugees have access to, are accessing and, are making sure they are meeting their needs.

Mental health is determined by a myriad of determinants including job stress, stress arising from food insecurity and poverty, social isolation and exclusion, depression, violence, cultural insensitivity and racism, and poor environmental conditions such as poor quality housing and geographic isolation, human rights violations.[25] These determinants are disproportionately experienced by vulnerable populations including refugees and immigrants.[26] Vulnerable populations currently experience inadequate support to deal with these determinants. The WHO (2013a) uses the term "vulnerable groups" in its mental health action plan for member states to refer to individuals or groups of individuals who are made vulnerable by the situations and environments that they are exposed to (as opposed to any inherent weakness of lack of capacity).

It is therefore paramount that governments strive to improve the mental health of all its citizens, as well as immigrants and refugees, through actions and policies that ideally include the promotion of mental well-being, the prevention of mental disorders, the protection of human rights and the care of those affected by mental disorders. To make this possible, adequate resources need to be appropriately channeled towards this end, including resources promoting and sustaining mental health services among the general population and vulnerable populations deemed prone to experiencing mental health challenges.

Healthy migrants are well-integrated migrants, as their sense of well-being affects their families, workplaces, schools their social interlocutors.[27] The Director General for the International Organization for Migration (IOM) aptly summed the business case for promoting the health and mental well-being of newcomers by saying:

> *The contribution migrants make to the social and economic development of both their countries of origin and destination is only made possible if migrants are physically and mentally healthy, regardless of their migration status.* [28] *[Our emphasis]*

At the same forum, the Director General of the WHO, who argued that advocating for, and provision of comprehensive health services to immigrants, at par with the local population, should be considered a human right[29] therefore urges the redress of health and social disparities by proactively identifying and providing appropriate support for groups at particular risk of mental illness who have poor access to services, such as refugees.

Other key reasons why refugees and immigrants should be a key focus of mental health services provision is given by Xu & McDonald (2010), stating that immigrant mental health issues are important to Canada's immigration policy development. First of all, they argue, mental health is key to measuring general population

health, because immigrants are part of Canadian society. It is therefore related to the cost and adequacy of the healthcare system. Secondly:

> *[T]he mental health of Canada's immigrant population is one important determinant of the costs and benefits of Canada's immigration policy, and relates to questions such as whether Canada is maximizing the returns of its large-scale immigration program* [30]

Past Experiences and Mental Health Needs

Immigrants and refugees settling in a new country tend to have physical and psychosocial needs that need to be addressed both for their own sake and that of their host societies.

While refugees and immigrants are settling in a new country they develop hopes and goals for the future, for their children and for generations to come. However, the result of experiences in their home counties of origin, which can include physical and psychological torture - in the case of refugees or asylum seekers - and experiences settling in a new country place refugees and immigrants among the most vulnerable of members of society.[31] Some experienced trauma in their home countries, and there is also the most common challenge of having lost family members and friends and, now in a new country most are separated from family and friends.[32]

Many studies have found refugees at increased risk of psychosis and other mental health problems compared to local populations and other immigrants, mainly due to what refugees go through to reach their destination countries.[33] The physical and psychological trauma experienced by refugees places them at higher risk of psychiatric disorders such as depression, suicide, psychosis, post-traumatic stress disorder, and substance misuse, as reported in numerous studies.[34]

Mental health determinants discussed above are disproportionately experienced by and disproportionately affect vulnerable populations including refugees and immigrants.[35] With regard to newcomers, current mental health services were deemed ill-prepared to deal with immigrants living with mental illness or mental health issues, because of key challenges including language, culture, social isolation, along with the resettlement stress they experience.[36] Hence the greater need for mental health services targeted at this group, as advocated in numerous international[37] and Canadian literature,[38] for more than two decades.

VII. Findings

Service Provision: Programs and Experiences

Interviews with representatives of organizations capture several key aspects on service provision, staffing, and clientele. Participants were drawn from immigrant-serving organizations, ethno-cultural organizations, mainstream organizations, and organizations that are umbrella bodies supporting immigrant-serving organizations. These qualitative findings were supported by quantitative data on service capacity and programs.

Conceptualization of Mental Health

The majority of participants providing services to newcomers defined mental health very broadly, encompassing the wide spectrum from (positive) mental health or wellness, through mental health issues, to the other end consisting of mental illness. While the positive end of the continuum was equated with, or labelled as 'mental well-being', the negative end of the continuum was labelled as a 'medical condition' requiring medical intervention. According to most participants, good mental health is free of stress or mental health issues. It is ideal for normal daily functioning *"through all kind of things, including crisis that a person is faced with in their life"* (Participant B). Most participants mentioned that their organization used the Canadian Mental Health Association definition of mental health[i].

Most participants attributed the prevalence of mental issues/problems among refugees to the trauma experienced in their home countries, during their passage to Canada, and to social isolation, and the stresses of coping with day-to-day survival. This broad approach of working on the root causes as exemplified here truly warrants a much broader view of mental health. For example one participant said:

> *We also have social workers who provide housing, income and well-being counselling which aim to provide a protective, safe environment, which in turn address people's mental well-being and mental health one away or the other* (Participant D).

This participant goes further to explain:

> *We see mental health service as a service that should be embedded within other programs and services, because we consider mental health as a wider spectrum and therefore in should be approached ...[by]...utiliz[ing] assets, experiences and knowledge of the community...*(Participant D).

Participants agreed that service provision, or any supports that are health or health-related, should be geared towards promoting wellness, which includes mental well-being.

According to one participant who saw isolation as contributing or exacerbating mental health issues, a holistic approach to dealing with it involves encouraging networking and recreational activities:

> *So keep telling people to work out and to exercise and to realize that they need this not only to keep their body fit but also because a holistic approach to treatment of mental issues requires...physical activity and exercise on a regular basis* (Participant B)

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[i] Mental health means striking a balance in all aspects of your life: social, physical, spiritual, economic and mental. Reaching a balance is a learning process. At times, you may tip the balance too much in one direction and have to find your footing again. – CMHA definition of Mental Health

Although this approach might not be holistic to the extent of identifying and dealing with the root causes, it is holistic enough to not think the medical approach has all the answers.

On the other hand, a few participants reported of narrower conceptualizations of mental health in their organizations. For example, one participant stated that their agency defined it in medical terms:

> *[M]ore associated with medication or clinical aspect…assessment… when we are hearing of mental health, we think of mental illness, mental depression, mental stress, areas in which you need assessment by a psychologist or therapist…we have made a distinction between mental health and mental well-being. That is an important distinction, because there is a limited medical usage of mental health* (Participant C).

A similar and narrow, clinical definition was given by this participant:

> *Mental health could mean many things, for example, it could relate to conditions such as delusional or violent behavioral manifestations, double personality disorder, schizophrenia, depression, post- traumatic stress disorder, or suicidal ideas. These are only examples of mental health conditions* (Participant K).

Another narrow definition given was:

> *The term mental health as used by AHS is geared towards services where they receive diagnosis* (Participant M).

However, this participant went on to note that mental health also meant psychological, mental and emotional health, which is more than clinical conceptions given above.

Definition of 'mental health' with a limited application is contrary to most who applied it more broadly, equating it with mental wellness/well-being, and reserving mental illness for the conditions requiring medical attention. An interesting way of defining mental health in a way that empowers the service user was given by one participant who said:

> *They do not have a clear definition of mental health…They work around how people define their health. When clients mention or talk about their life situation then they define it in that way* (Participant N).

This conceptualization is more in line with approaches to promoting health that focuses on what service users think, and allows providers to tailor their interventions to target what clients believe is causing their problems or illness. In a way, this SPO provides opportunities for a culturally inclusive definition of mental health. If a newcomer believes their mental health issues are being caused by, for example, the racism they are experiencing in school, the solution is worked out to solve racism, and not providing some psychotherapy to the newcomer.

General Services and Mental Health Services

Because participants were drawn from a wide spectrum of organizations, there is tremendous variability in terms of service provision. As shown in **Appendix B** and **Appendix C**, from the gamut of services provided, there is little translation into specific services for mental health. This is reflected in column 4 where there are gaps in 'mental health services' offered, as well as specialized staff or unit/department dedicated to the provision of these services in the likes of psychologists and social workers. To cope with this deficit, most organizations therefore refer clients needing mental health specialized services, hence 'referral' was included as a service in column 7. However, as described later in this section, most participants noted and emphasized the function of these 'general' services in promoting mental health. This is because they regard mental health in a much broader way than a focus on mental illness:

> *We also have social workers who provide housing, income and well-being counselling which aim to provide a protective, safe environment, which in turns address people's mental well-being and mental health one away or the other* (Participant D).

While participants' definitions might have given a broader conception of mental health, this is not presented here as justification for not providing mental health services that might be essential/ needed by newcomers.

Alberta Health Services

The only organization with the most comprehensive offering in terms of overall health-related services is Alberta Health Services (AHS) since it is the largest public health provider arm of the Ministry of Health (Alberta Health) (see **Appendix B** and **C**). In terms of therapeutic mental health services, or those targeted at specific, diagnosed mental health problems, this happens to be the largest provider in the province as well, through its mental health clinics.

AHS provides mental health services both in the community and in general clinical settings across the province, including in rural areas:

> *[G]enerally, in public health alone we mostly deal with situations such as acute mental health cases... We also deal with post-partum depression quite a bit... We do have general communication centres, so, if someone moves to a...[new] area we let them know of service availability and if we don't have the service in a specific area, then we refer the clients to where they can access the service* (Participant J).

In relation to this, AHS facilities widely disseminate information on available services:

> *[W]e are trying ...to make people familiar with the network of services that are available to them in various offices, facilities, communities and rural areas that are covered by Alberta Health Services* (Participant J).

The information also includes mental health services and where these services are provided. The referral system allows facilities that deal with general public health issues to refer clients needing mental health services to specific specialty centres.

Human Resources Providing Health Services for Alberta Health Services

AHS has over 108,000 employees, including over 99,900 direct AHS employees and more than 7,000 physicians. It is also supported by over 15,600 volunteers practicing in Alberta.[39]

Table 1: Distribution of Alberta Health Services Human Resources by Zone

Service Provider	*Calgary Zone*	*Central Zone*	*Edmonton Zone*	*North Zone*	*South Zone*	*Total*
Physicians	3,076	707	2,659	579	485	7,506
AHS Employees	37,000	12,631	32,657	10,411	7,238	99,937
Volunteers	4,623	3,292	2,680	3,083	1,933	15,611

The distribution of human resources favours metropolitan cities of Calgary and Edmonton. The distribution of human resources reveals that metropolitan areas, Calgary and Edmonton, have the highest number of physicians (Calgary: n=3,076 [41%] and Edmonton: n= 2,659 [35%]) and AHS employees (Calgary: n= 37,000 [37%] and Edmonton: n= 32,657 [33%]). The statistics indicate that 76% of doctors and 70% of AHS employees are in big cities while the remainder in small cities and rural communities. The health workers who are employed by AHS include those who provide mental health care in the province as shown in Figure 1 below. In Edmonton, paramedics and mental health professionals work in partnership to offer crisis help in the community. Crisis Response and EMS (CREMS) teams a paramedic and a mental health therapist/ nurse. They work collaboratively with mental health crisis services and other addiction and mental health programs together to meet the needs of patients and provide treatment in the community, thus avoiding unnecessary trips to the Emergency Department.

Figure 1: Health Workers Employed by AHS

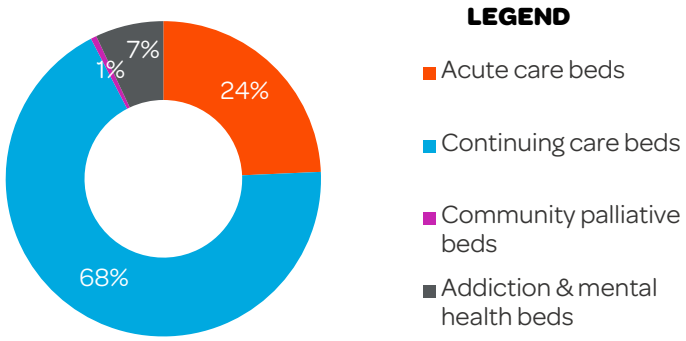
Mental Health Programs and Services Provided by Alberta Health Services

Alberta has mental health programs and services under AHS. These programs and services are offered at over 650 facilities throughout the province, including hospitals, clinics, continuing care facilities, cancer centres, mental health facilities, and community health sites.[40] The province also has an extensive network of community-based services designed to assist Albertans maintain and/or improve their health status.

According to AHS, no referral is necessary to access mental health services.[41] They are free to Albertans as the costs are covered by Alberta Health Care. Refugees arriving in Alberta will immediately have access to health care services. However, like anyone moving into the province, they will need to apply for health coverage under the Alberta Health Care Insurance Plan. Until the refugees receive their provincial health care card, they will be covered for up to one year under the Government of Canada's Interim Federal Health Program. This program repays the cost of care to health-care providers. To access mental health services, Albertans - including immigrants and refugees - can call to arrange for the service, or a medical practitioner can also refer them.

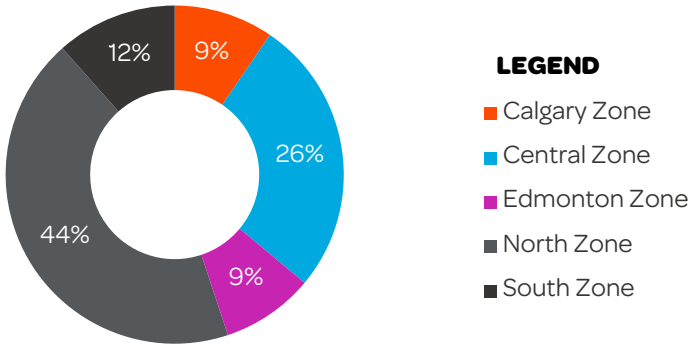
AHS provides the following mental health services: talk to callers as soon as possible (one business day); discuss problem with caller and develop a plan to meet needs; and provide mental health services through community programs.[42] AHS provides assessment, diagnosis, treatment, therapy and support; referrals to other professional or community agencies when appropriate; services and support to mental health patients discharged from hospitals to assist them in returning to community life; provides information to individuals, community agencies or groups about mental health/ illness and suicide prevention; and engages in mental health promotion and prevention; and support for the seriously mentally ill in the community.[43] AHS has a number of facilities to provide these services as shown in Figure 2.

Figure 2: Types of Health Facilities Provided by Alberta Health Services



AHS has 106 acute care hospitals, five stand-alone psychiatric facilities, 8,471 acute care beds, 23,742 continuing care beds/spaces and 208 community palliative and hospice beds, 2,439 addiction and mental health beds.[44] These facilities are available to all Albertans who require the services. Among these Albertans are newcomers who are refugees and immigrants. While mental health is one of the main challenges faced by refugees and immigrants, only 7% of AHS's facilities are for addiction and mental health.[45] The other facilities are for acute care (24%), continuing care (68%), and community and palliative care (1%).[46] However, AHS advises those seeking mental health services to go through community health centres, which are found across the province.

Figure 3: Distribution of Facilities Provided by Alberta Health Services by Zones



AHS is a province-wide health service provider that has community health services in all the five zones that divide the province. It provides services in both the metropolitan cities of Calgary and Edmonton, as well as in small cities and rural communities. The distribution of AHS' facilities in these zones is as follows: the North Zone has the majority of the services (44%) followed by the Central Zone (26%), South Zone (12%), Calgary Zone (9%) and Edmonton Zone (9%). Calgary Zone and Edmonton Zone, which are the largest urban areas and where most refugees and immigrants are settled, have the lowest and an equal distribution of health care facilities. There are more facilities in Northern Alberta because of the many communities that are distributed over the region.

AHS provides a variety of health care services in Alberta. The services are provided to all residents of Alberta, including refugees and immigrants. There are no services that are specific to refugees and immigrants, which might also imply that AHS does not provide culturally specific or appropriate mental health services and health services in general. However, while each service might be for a specific component of the individual's health needs, all the services contribute to mental health care in a holistic way. A breakdown of the distribution of

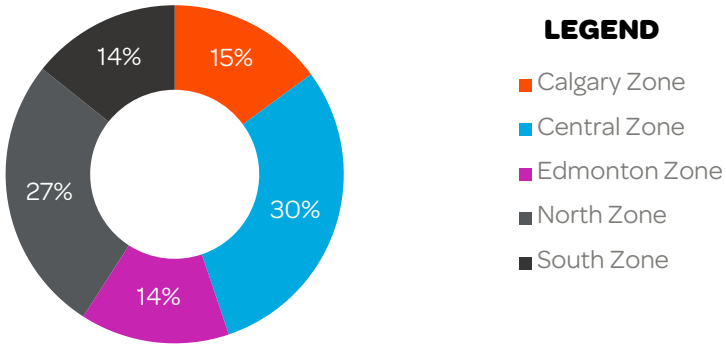
health services by AHS in Edmonton, Red Deer, Calgary, Grande Prairie, Fort McMurray, Lethbridge, and Medicine Hat is in **Appendix A: Types of Health Services Provided by AHS**. From the list of services, there are some that are closely related to the provision of mental health services. These are: addictions and substance abuse, continuing care, the general health system, mental health and wellness, social and family issues and wellness and lifestyle.

Community Health Centres

According to AHS, where specific programs and services for mental health are not available, they are instead provided through local/community health centres. Community or local health centres provide services for the treatment and care of people with mental health or addiction challenges.

Rural communities, Central Zone (30%) and North Zone (27%) have the highest numbers of mental health services compared to metropolitan cities, Calgary (15%) and Edmonton (14%), and the South Zone (14%). While more people live in urban areas, the spread of rural communities in Central, North and South Zones necessitates the provision of services in each community. Even when it comes to the number of hospitals in each zone, the highest numbers are North Zone (n=34) and Central Zone (n=30) and the other three zones have 14 hospitals each. **Tables 3 to 7** in **Appendix A** indicate the local/community health centres that are available in each zone. These are the centres that provide mental health services to Albertans, including refugees and immigrants with more centres found in rural communities than urban areas.

Figure 4: Distribution of Mental Health Services in Alberta



Clientele, Frequency of Use & Accessibility

In terms of gender, the majority of clients seeking mental health services or related services such as settlement advice/information, are women. In terms of age, the range is from those in high school to those over 75, particularly given that some services are specifically designed for those going to school. While the ethno-specific organizations (e.g., Indo-Canadian Women's Association) tended to serve newcomers from specific ethnic backgrounds, other ethnic groups are welcome.

Agencies serving immigrants and refugees (e.g., Mennonite Centre for Newcomers) saw a significant number of refugees from countries that have recently experienced political upheavals/instability or economic meltdown, such as Afghanistan, Bosnia, Congo, Eritrea, Nepal, Somalia, Sudan, Syria, and Zimbabwe. Mainstream organizations that provide services to all Albertans (e.g., AHS, YMCA, Catholic Social Services) serve a varied mix of non-immigrants (e.g., Indigenous population) and newcomers from chief immigrant source countries (e.g., India, China, Philippines, African countries), and refugee source countries. Other newcomer source countries in South East Asia that were mentioned include Pakistan and Bangladesh. Eastern Europe was also noted as a source of immigrants and refugees accessing different types of services in these organizations.

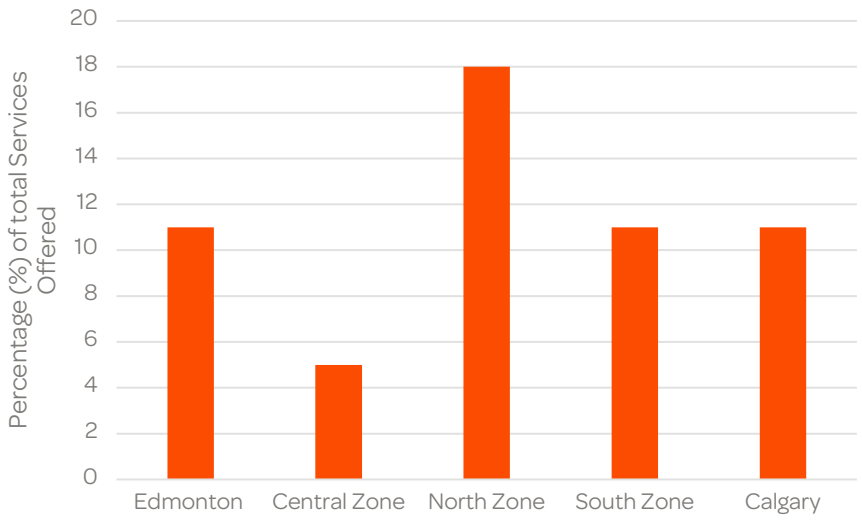
In terms of overall numbers of clients, and number of facilities available, AHS appears to be the leading organization that is affording a wider access to newcomers seeking therapeutic mental health services. In terms of numbers:

> *Well, last year…we served about a thousand Syrians. Normally … Edmonton …sees an average of 400 refugees and newcomers each year. That is the normal number of refugees we serve. But since the Syrian refugees came to Edmonton last year, we now see a lot more refugees. Now 50% of the refugees we see are Syrians and 50% are refugees from other countries* (Participant J).

Dedicated Unit/Section and Human Resources Providing Mental Health Services to Refugees and Immigrants

There are many agencies (i.e., immigrant-serving agencies and ethno-cultural agencies) that provide services to help with the settlement of immigrants and refugees and their families in Alberta (see **Appendix B** and **C**). There are more agencies in metropolitan cities, Calgary (35) and Edmonton (30) than in small cities where 17 agencies are in North Zone (Grande Prairie and Fort McMurray), 11 in South Zone (Brooks, Lethbridge and Medicine Hat) and 8 in Central Zone (Lloydminster and Red Deer). For more information on these agencies see **Appendix A Tables 8 -12**. The fraction of services and programs provided by immigrant serving agencies dedicated to mental health and counselling services are provided below. Please see **Appendix A : Immigrant Serving Agencies and Types of Services** for a breakdown of services for each zone.

Figure 5: Mental Health & Counselling Services: Immigrant Serving Agencies



Outside this category, there are very few agencies with a dedicated team/unit, or professionals who address the clinical aspects of mental health of newcomers. As most participants indicated, newcomers with such mental health needs are referred to specialists in the mainstream agencies or to private practitioners. Those that can handle the non-clinical aspects employ psychologists, social workers, and counsellors. Related support needs in organizations without this specialized help have settlement counsellors to assist them.

However, participants defined mental health broadly, and take the mental health promotion approach. This preventative approach takes cognizance of the root causes of mental health problems among refugees and immigrants. Those who espouse this view, even when they do not have mental health professionals in their organization, the work they are doing to help newcomers to settle, to deal with daily struggles (e.g., child care, employment, housing, discrimination, etc.) that 'cause' stress and other mental health problems, is already making its mark in keeping those problems away.

There are many mainstream organizations providing mental health services to all Albertans, without specifically having a unit or staff dedicated to providing these services to newcomers. While newcomers are welcome in these facilities, one challenge is that of language and cultural barriers preventing newcomers from

communicating effectively enough with providers to fully benefit from these clinical encounters. Moreover, the lack of service providers with cultural competence to provide services that meet the needs and cultural expectations of newcomers also renders these encounters unproductive.

Of all service providers interviewed, AHS is leading in terms of availing specific units that deal with mental health issues among refugees and immigrants. The Refugee Clinics (or Canadian Clinics) in Alberta, have partnered with Catholic Social Services to do health intakes of all government-assisted refugees every year. In addition to this, refugees get immunized and referred to other public health centres close to where they live, for follow up, or consultation for other health issues.

According to a participant from the Ministry of Health:

> *If immigrants, newcomers or refugees seek mental health services, they can go, for example, to Misericordia Hospital, University of Alberta Hospital and other Alberta Health Services facilities where they can access the service... Not only refugees and newcomers but also permanent residents have access or rights to services of the government of Alberta* (Participant K).

This participant goes further to provide details on the availability of mental health services for different categories of newcomers by saying:

> *If you are here as a refugee, newcomer or immigrant who has...legal status ... you have access to mental health services and other health services wherever you live, including in rural areas. If you are not a landed immigrant...[but]...a visitor to Canada you can still access health services including mental health services, although in this case you are required to purchase health insurance or you will have to pay for the service out of pocket* (Participant K).
>
> *In rural areas though, where AHS contracts other agencies to provide mental health services, "newcomers in those areas are able to access government [mental] health services" this way* (Participant K).

Language used, diversity and cultural competence

From the data collected, it seems that most organizations do struggle to meet the language needs of refugee and immigrant clients. The exception is mostly ethno-specific organizations and immigrant-serving organizations that employ a sizable number of individuals from the ethnic groups served. Those employed can communicate easily with service users, and have experiential knowledge of their culture, expectations, and support needs. The need for language representation is emphasized by one participant who said:

> *When an immigrant cannot speak English the service providers struggle to grasp the root cause of an immigrant's problem that they are presenting (Participant A).*

And the need for diversity and cultural competence was emphasized by another participant who stated:

> *We are also introducing into our program African psychologists to help our clients with mental health concerns, so that mental health clients experience and appreciate a service provided by African mental health service providers (Participant D).*

Agencies that do not have providers who speak the language(s) of clients have to contract translators from other organizations or independent contractors or individuals from surrounding communities. The problem with this strategy, as exemplified by the case of a newcomer (described in the above section) whose family member had a tooth problem needing urgent medical attention and the attendant translation between the doctor and family, is that it takes days to get hold of a translator. In this case it took three days to do so. This was confirmed by the account of an organizational representative who said it took them a minimum of two days to get hold of interpreters. That aspect of their service made the service provider to assert, *"If I needed services I would not come to us..."*

Many agencies rely heavily on staff to translate for clients from the same ethnic background as themselves (e.g., Arabic for a newcomer from any Arabic-speaking African or Middle Eastern country), or clients who spoke the same language (e.g., French for newcomers from African countries). However, some indicated that they relied on "...family members or friends [for] interpretation," apart from staff. Despite the fact that French is one of the

two official languages in Canada, most agencies have referred newcomers who speak French (eg., from West African Countries) to Francophone agencies serving French-speaking. However, there are fewer of these agencies in Alberta.

However, AHS, being the largest provider of mental health services in the province, works with a variety of languages, made possible by access to the 'language line'. However, a language line request which involves tele-interpretors should be made in advance:

> *If we have refugees needing language services, we work with language lines . As soon as we have a refugee or if someone moves to Canada and is needing language or interpretation services, my staff are skilled in using telephone language line (Participant J).*

Moreover, compared to smaller agencies that are strapped for funding to hire interpreters, AHS also has resources to utilize interpreters, particularly for mass interventions:

> *When we are providing mass services, like when we have mass influenza or mass immunization, we use in-person interpretation services in which we bring in interpreters in-person to help with interpretation. (Participant J).*

For clients that speak English or French, they do have staff who can speak English and French, who work directly with those clients. Therefore, for AHS, according to this participant, the "...language issue isn't a problem..."

Composition of staff (gender, race, and ethnicity)

The lack of translators is related to the lack of diversity in terms of ethnicity to some extent. Diversity in terms of gender, and other characteristics are also key to analyzing how inclusive an organization is. **Table 2** shows that the majority of service recipients are female. In terms of ethnic representation, one participant said:

> *[There needs to be] improvements in recruitment to ensure that multicultural staff are recruited who have both social work training and education from where they came from and also here* (Participant B).

While a good number of agencies do not have a representation of ethnic minority or racial groups on their roster, several agency representatives noted the diversity in their organization in terms of ethnic representation to cater for the various client groups they support (See Table 2). Only one seemed to express contentment at the level of diversity in their organization:

> *[We have] 12 staff... East Indian, East African, South Asian, Chinese, Vietnamese, Latino, and Spanish-speaking...[we are] diverse in terms of gender, ethnicity, and sexual orientation... No Caucasian staff* (Participant H).

However, some of the numbers seem so small in terms of gender representation that one participant noted:

> *Women are more than men by far, at a ratio of three women to one man. In terms of ethnicity, I would say all our staff are culturally diverse, I only have one mainstream Canadian on our staff. Everybody else is immigrant, visible minority, newcomer* (Participant C).

Adequacy of Resources

Human Resources

Overall, most representatives highlighted the lack of resources, particularly human resources, that inhibit their organization from effective realization of set goals and objectives. To the issue of resources, two participants said:

> *There are insufficient resources to address the mental health crisis...we are hugely under-resourced... We can't hire enough staff or pull together all the resources we need to be able to help people enough* (Participant B).

We do have one individual who deals with complex scenarios, but that is only one individual. So, as an agency I don't think we have a mental health program as such…this service is helping clients more with immigration issues and sponsorship of their relatives than mental health (Participant C).

In terms of human resource numbers to deal with general resettlement issues there was one service provider though, who seemed satisfied with their recent acquisition of 20 new personnel to assist with their settlement program:

So that is a big number, nobody is getting such a number, so I don't want to complain… We have seen the positive impact of that in terms of expanded services. So, for now I can say we are just good. Hopefully in the future that can be sustained or even increased, but for now I can say we are quite good, we are in a very comfortable position. (Participant C).

AHS, the largest provider of mental health services in the province is also adequately resourced, according to one participant. Resourcing for mental health services provision is considered unproblematic:

I don't think that is a real problem for Alberta Health Services. AHS services are provided for free or are covered by Alberta Health care system…I haven't really noticed any lack of financial resources … in the way of treatment for refugees and newcomers (Participant J).

This positive sentiment about the adequacy of resources to deal with mental health services is echoed by a participant from the Ministry of Health who says:

The government has always been in the business of providing mental health services to the population…There are practitioners and specialists available at different Alberta Health Services hospitals and health care centres. For example, there maybe addiction and mental health units within Alberta Health Services hospitals (Participant K).

This participant admits though that:

There have been human resources challenges, especially in relation to specialists; but there is a room for improvement (Participant K).

Other Resources

Part and parcel of the human resource challenge is related to inadequate financial resources directed towards mental health problems among newcomers. As such, without sustainable funding, most agencies are in a continual cycle of applying for grants to stay afloat. Hence one says, "We need a lot of everything because there is a lot of demand," (Participant L). And another stated:

[We need] funding because the immigrants are coming…with huge mental health issues and we need funding to be able to meet their needs in the most effective way (Participant M).

Other participants also mentioned the lack of resources on the part of newcomers as a reason for not accessing available mental health services. A key resource that many newcomers fall short on is transportation. Without transportation newcomers are not able to fully access mental health services when they want them. According to one participant:

It is quite difficult for refugees to keep appointments because of transportation difficulties (Participant J).

According to this participant, financial resources to pay for AHS mental health services for newly arrived refugees is not a problem because the services are free. It is later when their legal status does not allow them to receive free services that financial resources become an issue.

We don't see refugees with mental health issues that surface later in refugees' lives after they have settled here, though. But we see them [soon after arrival] when they have acute mental health issues. If they need counselling later in life, then [they] definitely have to pay for that or they may need to access funding resources, and those funding resources can be difficult to access. I haven't really noticed any lack of financial resources that are in the way of treatment for refugees and newcomers (Participant J).

However, provision of free services amidst a number of other constraining factors related to finances (e.g., lack of childcare and transportation), and lack of time because newcomers need to do other important activities defining their lives (e.g., attend language classes, take children to school, look for a job), will still prevent them from accessing these free mental health services. Moreover, what this participant is saying about free mental health services for refugees soon after arrival is not helpful, because most mental health issues surface later, when they no longer have access to free services:

> *[W]e work with refugees basically between their immediate arrival and two months at most after their arrival. At that early time, mental health is not often a concern at best. When someone comes to us with a lot of horrific stories then we refer them. We may have not even noticed mental health issues at that early time after their arrival here. At the time of arrival people are just happy to be here, overwhelmed, settling in the new country. So mental health becomes more apparent or surfaces, I would say, maybe after half a year of being here, when the kids are in school, when parents are at home having to face paying the bills, or trying to catch up with a busy lifestyle here in Canada. That is about the time when issues about loss, grief, and mental health issues begin settling in* (Participant J).

Wait Times

Largely tied to human and financial resource limitations, one of the key gaps preventing efficient provision of mental health services is wait times. According to a participant from AHS, the largest player in mental health services in the province:

> *...wait times to get in to see mental health professionals are long...and that's probably one of the mental health gaps we are still struggling with* (Participant J).

This sentiment is echoed by a provider outside AHS, who also has the perception that accessing AHS mental health services is not easy, and says:

> *AHS is tricky to access and even more challenging for immigrants and refugees. There is a long wait list...The intake process needs to be simplified...to be relational to build rapport, trust, listening, a welcoming environment* (Participant L).

Referrals

This study found that a lack of professionals dedicated to the provision of mental health services in the organizations examined, resulted in an increased number of referrals to mainstream agencies. Agencies that were referred to include AHS, and some of the well-established agencies that have multiple branches across the province, such as Catholic Social Services.

However, agencies also get referrals from other immigrant-serving organizations that do not have the appropriate resources to deal with the mental health needs of newcomers. Family physicians also refer newcomers to refugee-serving agencies because of their expertise dealing with newcomers mental health needs, particularly where the agency has staff that speak the language of the newcomer seeking mental health services.

AHS public health facilities refer newcomers to specialized units or specialists (e.g., social workers and mental health therapists) within AHS for mental health services. But, surprisingly, while we have heard from immigrant and refugee-serving organizations that they refer clients to AHS, there are reciprocal referrals from AHS back to these agencies:

> *In our refugee clinic, new Canadians clinic, there is mental health services...However, most often, because refugees and newcomers are already connected with settlement counsellors and agencies serving refugees and newcomers in the community, we refer refugees with mental health issues to settlement agencies with mental health programs serving refugees. We are often in these cases associated with Edmonton Mennonite Centre for Newcomers. Because of this we don't even tend to refer clients to Alberta Health Services [i.e., refugee clinic], but to Edmonton Mennonite Centre for Newcomers because they have the expertise to deal with refugees and newcomers. But we also refer to mental health clinic at East Edmonton Public Health Centre* (Participant J).

Apart from the Mennonite Centre, Catholic Social Services is one other agency with this reciprocal referral arrangement with AHS.

Stigma

According to most participants, stigma surrounds the issue of mental health, particularly amongst most newcomer groups. The existence of stigma around mental health makes it hard for people to accept that they have a problem, which they need to get help for. With some, it is the fact that they do not want to be treated differently, so they do not open up. Stigma relegates mental illness to the "elephant in the room," as said by participant 'I'. Stigma is a reality for many people with a mental illness, and they report that how others judge them is one of their greatest barriers to a complete and satisfying life. On stigma, some participants said:

> *Our staff struggle…to convince newcomers with mental health issues to admit they have the problem so that they can get the help they need* (Participant B).

> *Most immigrants and refugees come from collective cultures and they hide the condition of mental health for fear of punishment, stigma, and exclusion because in most cultures mental health is an undesirable state* (Participant H).

The lives of people with mental health conditions are often plagued by stigma as well as discrimination. Existence of stigma also means people do not seek help in time, and only do so after concerns have escalated to mental problems. At this stage therefore, only treatment is required, and not prevention.

Given the stigma surrounding mental health/illness, service agencies would need to provide an environment where clients feel safe to talk about their experiences and conditions:

> *Services should be provided in places where people feel safe, where people are not targeted or identified in some negative light because of the stigma that typically surrounds mental health conversation* (Participant D).

Due to the stigma associated with mental illness, many people have found that they lose their self-esteem and have difficulty making friends. Sometimes, the stigma attached to mental health conditions is so pervasive that people who suspect that they might have a mental health condition are unwilling to seek help for fear of what others may think. Further complicating the issue of stigma is the fact that:

> *…many newcomers come from a culture where there is mistrust …[that] inhibits their access to mental health services and supports because they do not want to be viewed as complainers and fear to be kicked out [i.e. deported] if they say what they are dealing with* (Participant G).

When asked what their agency is doing about stigma, one participant said that they do an awareness campaign through education. The education is meant to normalize mental health challenges, by mentioning that others have dealt with same challenges and have sought help that has helped them. They also work with partners to educate other service providers on how to reduce stigma.

Holistic Approach

According to some providers there is *"lack of holistic treatment for people with mental health issues"* (Participant B). This problem is partly caused by failing to define the problem in a holistic way, which would ordinarily prescribe a holistic approach to solving the problem. It also has to do with the training health professionals receive, for *example "[i]n North America [making the] medical…[more] treatment-based, relying heavily on drug treatment of patients, including mental health patients"* (Participant B). In other words, she goes on to say, *"[t]here is lack of alternative, holistic approaches."* According to participant 'A', the medical bias in the treatment of mental health issues led to the inability of the doctor treating him for persistent headaches to fail to get to the root cause, as well as refer him to more appropriate services.

The lack of treating mental health in a holistic way in service delivery is also blamed on the wider Western culture, which emphasized treatment of symptoms. The lack of cultural definitions of mental health and wellness in the western medical field poses challenges for refugees and immigrants. The meaning may be in the deep-seated attitudes and beliefs a culture holds about whether an illness is "real" or "imagined," or whether it is of the body or the mind (or both). Therefore, understanding individual and cultural beliefs about mental illness is essential for the implementation of effective approaches to mental health care. According to one participant:

> *In ethno-cultural societies, mental health is holistic in terms of 'mind, body, and spirit.' There are different explanations for what might be perceived mental illness. People who hear voices might be defined as gifted – the supernatural worldview. In Chinese culture, mental illness is purification of the spirit-someone might not seek help until it is too late* (Participant H).

Therefore, cultural competence is needed in order to understand what is really influencing the way newcomers are reacting to their new environment. Cultural competence gives one that extra 'eye' to see some of those root causes embedded in culture and norms of behavior.

Others conceptualized 'holistic approach' in the sense of having professionals who come from the same cultural background as their clients. Presenting mental health care services in culturally-sensitive ways using ethno-cultural professionals may be essential to increasing access to and usage of mental health care services, as local beliefs about mental health often differ from the Western biomedical perspective on mental illness. This was noted by one participant who said:

> *We are also introducing into our program African psychologists to help our clients with mental health concerns, so that mental health clients experience and appreciate a service provided by African mental health service providers. This is an attempt to what we call holistic approach* (Participant D).

It can also be conceptualized as failure on the part of the settlement service model who ignore the pre-migration experiences of service users. In most cases, refugees undergo traumatic experiences before arrival, hence it is unrealistic to expect the mental health issues of a multi-generational family to "go away in three years" because they are multi-dimensional.

Coordination Among Providers

Many participants pointed out the lack of coordination/collaboration among providers of mental health services as a key failing in the system. With greater collaboration comes awareness of what each organization serving newcomers is doing and can do, as well as 'how' best to make referrals to them for 'what' types of mental health needs and services. On one hand, when agencies do not know what the other agencies are doing, newcomers will not know much about their services and this will negatively impact the quality of referrals. On the other hand, when each agency has information about other agencies, it helps in letting users (i.e., newcomers) know what is available and where.

> According to one participant therefore, their experience is like:
>
> *[T]he communit[ies] are struggling a little bit…we speak to people who don't know we have the services…[but]…even if they know about the service they don't how to access it…We are not getting many mental health referrals…there must be a disconnect somewhere…So communication between various healthcare giver organizations to create awareness among themselves about the existence of services …would be helpful* (Participant J).

With enhanced communication among providers, comes greater awareness and working out of strategies to work together. When agencies do not know what each one does, you get this kind of reaction from someone working in a sizable organization saying this about AHS: *"…don't know if they provide interpretation"* (Participant L).

Currently, without much collaboration, agencies providing mental health services are working in silos. Working together, however, would help agencies pool resources, or make timely referrals for particular services best provided elsewhere, without stretching their limited resources:

> *[C]ommunity services organizations work so alone, independent…more in isolation…[T]hey do excellent work, but they are independent. But when the[y]… are maxed out…[or] clients need more than what they can provide, they are stuck, because they are not part of the network…And then they struggle, because they have no network to refer people to. I can be well intending, I can provide this and that…for a client, but it becomes too individually focused and eventually I am going to burn out and max myself out of resources. That is why we need a network of people around us to assist us* (Participant J).

Worker Fatigue and Vicarious Trauma

One participant mentioned one key challenge that is part and parcel of the caring profession. With prolonged provision of supportive care comes burnout; as service providers become fatigued and stressed out because of hearing and dealing with the traumatic stories of what refugees went through before reaching Canada.

> *[One] problem we see is that our staff are serving refugees who come with stories which are quite difficult because of the problems they carry with them and experiences they went through. These stories are quite stressful and impact on staff. Our staff sometimes burn out because it's just too much on them. For staff dealing with those stories it becomes a question of how much is too much. For example, I have one nurse who mainly helps with refugee intake work, and then I have two other people who have been trained to be able to do the same job in order for that … nurse to take a break … when it gets too much* (Participant J).

Refugee and Non-Refugee Perspectives

In-depth interviews with newcomers in Canada have shed light on some of the challenges both refugees and immigrants face in accessing and obtaining relevant mental health service support. These qualitative findings are based on a sample of six refugees and three non-refugees. All participants were married. The education levels varied with refugees reporting lower education level at elementary level while the non-refugees who had higher qualifications at post-secondary level. All refugee participants were not employed except for one who arrived in 2000. The rest of the participants had been in Canada in the last two years.

Interview Sample at a glance:

Total = 9
Male: 7; Female = 2
Participants between the ages 34-48
Year of entry 2000-2016

Causes of Mental Health Problems

Some refugee families are relocated without all of their family members. Some are displaced and relocated without their fathers and husbands, while refugee children might be separated from both parents. This separation can cause a breakdown in family structure and impact children and families not only in economic ways, but emotionally as well. Family separation impacts the well-being of refugees. Leaving family members behind, and going through the process of relocation alone, leads to intense anxiety for the safety of those left behind. Fear for family contributes more to current distress than traumatic memories, especially once refugees have arrived in their country of final relocation. A participant in Lethbridge reported that his mental health issues were caused by separation from family members and the situation of those family members left back home. While they have been received and settled in Canada, they were concerned about members of the family left in Lebanon.

> *"But our main mental health concern has to do with what we went through before coming to Canada. I have been away from my country, Syria, for nine years, my dad is in Syria and I haven't heard from him. We have other family members that I have not been in contact with for so long and I don't know they are right now as we speak. I have two brothers in Lebanon who have not been registered with United Nations High Commissioner for Refugees (UNHCR), so they are on their own in Lebanon, without help from anybody.*
>
> *My family and I arrived in Canada and were fine here. We get what we need – food, safety, school for our kids and for ourselves as parents, etc., but we don't know if those we left home have even food to eat."*

Health and well-being is a matter of concern for refugees. Refugees settling in Canada face many difficulties in accessing effective health care. These have been widely documented by health service providers. Lack of access to health services affects their mental health and well-being. Limited finances also makes the use of private dentists prohibitive. Most newly-arrived refugee groups have significant oral health care needs and their reliance on public dental services is problematic. The participant in Lethbridge pointed out that his mental health problems in Canada emanated from lack of medical insurance to cover his son's dental problems. The processing of insurance coverage for refugees is lengthy. At the same time, financial constraints are almost universal for people who arrive as humanitarian refugees and who have yet to find employment.

> *I have a concern regarding my 11-year old son who has a big dental health problem that needs to be solved. We are told his dental problem would cost $2,000 to fix; I can't afford to pay that amount. We are told they are looking for insurance to help cover the costs but we have been waiting until now and insurance has not been found yet. We have been waiting for that insurance since last year and the waiting has been tough on my son, my wife and myself because his tooth is hurting him and he is always in pain, to the extent sometimes he cannot go to his school because of dental pain from that affected tooth. They give him pain killers to deal with pain, but that is not treating the problem. My son is not happy because of that. These are the issues that are concerning to me and my wife.*

A participant in a large centre said that she experienced personal problems when she was new in the country. She managed to access services at the [Organization A]. Depression, stress and anxiety are common among lonely new arrivals who have no social support. Refugees are a particularly vulnerable population at risk for mental health problems after traumatic experiences and adjustment problems in the country of resettlement. Lack of support and information on accessing mental health services like counselling might exacerbate mental health problems.

> *First I was going through personal issues. I had a miscarriage, then depression after miscarriage; I was not feeling good. I was feeling lonely, no friends around to talk about my issues. I was new in this country, I knew nobody, only my husband. I was attending English language classes at [centre A]. My English language teacher observed my situation; so, she advised me to seek counselling. She advised me where I needed to.*

Individuals who become refugees may face a wide variety of traumatic events. They may witness fighting and destruction, observe violent acts perpetrated against loved ones, or be subjected to physical violence or witness sexual violence. One participant from Syria said that some of his mental health problems are due to the situation he went through back home. He has post-traumatic stress disorder (PTSD) that is a result of the war experiences he went through in Syria. In addition to PTSD, separation from family and a feeling of loss exacerbate mental health issues in a new country. As a father, the Syrian participant feels that he is not doing enough to look after his disintegrated family.

> *I have depression and other health problems that started in Syria after the war broke out in my country. I was tortured repeatedly…[explicit]…Sometimes I feel half normal mentally from those blows to my head. My larger family is scattered. My dad is sick and he is still in Jordan, with my mom in refugee camps in Jordan, not knowing the future for them. Some of my daughters are in still in Syria and we haven't heard from their husbands.*

Being in a new country with limited or no access to health services could be a cause of worry, anxiety, and stress. Physical wellness promotes proper care of the body for optimal health and functioning. Overall physical wellness encourages the balance of physical activity, nutrition and mental well-being. One participant complained about how physical health challenges were negatively impacting his mental health:

> *My immediate family, me, my wife and young children are here with me, but with so many problems – I myself I am sick, with heart problem, terrible back pain from a previous surgery to support backbone; and now diabetes. My wife is sick, being diagnosed recently with hepatitis. My younger son is also with health problems. All these problems cause a lot of pressure, stress and worsen my depression and mental health situation. Sometimes I feel suffocating.*

Language Barriers

When English is not one's mother tongue, the ability to convey intended meaning, read and understand instructions becomes difficult. Language proficiency is a major barrier for some recent immigrants and refugees. For anyone seeking help, it is extremely important that they be able to communicate in their language of choice without the use of interpreters and translators. One participant said that he could not access services easily because of language. He and his family did not feel independent. The government financial support was inadequate. He was spending most of his time in school and not working.

> *In terms of language, we obviously needed help with language. So, they always provided us with an interpreter whenever we accessed services. Although we arrived more than a year ago, my wife and I still can't access services or communicate in English without interpretation. The language is the key to everything. If we know the language, we would be independent; we would be able to work and take care of ourselves without depending on the government. Although the government is supporting us with financial salaries monthly, that support is barely enough to cover our needs.*

Some participants reported that language was not a complete barrier as long as it was simplified for them. Learning to speak the local language, particularly English, greatly facilitates social integration and therefore also leads to reductions in overall stress. While simplified instructions in English might help, language difficulties influence the well-being of refugees throughout the arduous relocation and settlement process. A participant from Morocco said:

> *In terms of language, it was a bit difficult because I didn't know much English language. The mental health counsellor was very helpful because she was able to explain everything in simple English and in many different was so that I could understand.*

> *"My counsellor was excellent in explaining in many ways in order that I understand. For instance, if I didn't understand a word or words, she would use another word or words and explain in many ways to simplify and explain things to me. So, in the end I was able to understand her. I didn't even need an interpreter because my mental health counsellor was so excellent in using different ways to explain and, easy, simple English that made it easy to make me to understand.*

Transportation

Transportation access and mobility are crucial elements of a successful resettlement process. Furthermore, limited transportation options can in substantial ways restrict the autonomy and independence of refugees. It leaves them, in most cases, dependent on the services and schedules of others, which in turn can adversely affect their ability to seek and secure gainful employment, receive necessary medical care, and access other goods and services vital to survival, such as food and clothing. It was noted that accessing services was difficult without transportation. Moving around was more difficult in winter with the snow and the cold.

> *In terms of transportation, at the beginning it was hard moving around, especially during the winter months. The winter, cold and snow made moving around with my children and my wife particularly hard. VIII. Initial Reception*

Wait Times

With the influx of refugees in the country in recent months, the potential bottleneck of casework for health-care providers is huge, and it becomes a challenge for health care providers to integrate newcomers with already strained resources. The influx may result in longer wait times before seeing a health care provider as reported by one participant in a small centre. The participant reported that he did not seek mental health services but referred friends to centers with services. However, the participant complained about the lengthy wait time his friend was supposed to endure before receiving the services. Some refugees, like the participant's friend, are discouraged from accessing mental health services by the long wait time to see service providers, such as counsellors, psychologists, doctors or social workers.

I never went to any doctor, counsellor or social worker to talk about mental health. But I referred people with mental health issues to Canadian Mental Health Association as mentioned earlier. I also tried to refer people to organization A...). I tried to refer friends to that organization but they said: "Waiting time is 4 -5 weeks, so I told them 'Oh my God if someone survives four weeks why do they need your services.'" So, that why it didn't work, meaning the people I tried to refer to that organization didn't get that service because the waiting time was so long.

The wait time was also reported by a participant from Syria who said that the wait times to see a psychologist are long. The participant blamed bureaucracy within some mental health services for the long delays in seeing specialists or professionals by those seeking help.

My family doctor tried his best to contact the mental health specialist -psychologist and psychiatrist and managed to make an appointment to meet the specialist after nine months. "It's a killing long wait; it's a killing bureaucracy. I have to wait nine months just to meet the specialist."

Communication with Service Providers

Communication between newcomers and service providers is vital in the provision of mental health services and other health-related problems. Because few psychotherapists are conversant in the languages spoken by their refugee clients, mental health programs have traditionally relied on interpreters, often refugees themselves, to facilitate communication between therapists and clients. Some refugees volunteer to offer their interpretation and translation services to organizations that are in need of their help. However, sometimes service providers are not responsive to the offer to volunteer services by newcomers. A participant in Fort McMurray, a small centre, said that his calls to a service provider were not returned.

For example, I was calling...to access services or to assist with interpretation but they were not returning my calls. As you know, if you don't know the language you can't do anything, you can't go anywhere. I found interpreters on my own, for example, I came to know some Sudanese, Syrians, and Lebanese friends who have been here for quite some time and know the language. I got their phone numbers and I would call them whenever I needed help with interpretation.

Refugees and immigrants who volunteer to provide translation and interpretation services that are required by refugee and immigrant services agencies feel that they are contributing to the cultural needs of their communities. Being active and 'useful' in the community has a positive effect on their mental health as they feel connected to the community.

Quality of Mental Health Services

Participants said that some of the services from the physician were directed at clinical solutions. This may not always be appropriate, particularly in terms of targeted mental health problems. Medication prescribed and administered by physicians was a stopgap measure since physicians were the gate-keepers who controlled the referrals to mental health specialists. This setup could either hinder or facilitate access to appropriate counselling and psychological services and therapy.

But meanwhile, my family doctor has prescribed two medications to deal with my mental health issues, with my depression, but these medications are not helping me much, they are only making me fat and causing me side effects – it's causing me problems with memory; and this is the reason I am taking time off from my English language school. Because of memory issues that the mental health medications are causing me. I feel like my classmates think I am a dumb, so that is the reason I have decided to take off from school, for weeks. These medications are not meant to deal directly with mental health problems, but just to calm the situation down while waiting for my appointment with a mental health specialist.

Referrals

Referrals are important to linking refugees and immigrants to appropriate services for their needs. The issue of cultural competence was also related to that of referrals. For example, one participant, who also as an immigrant with a previous case of persistent headaches that he felt was not appropriately handled, said

"...Physicians...are gatekeepers..." in the sense that *"...for any problem, even social problems...to them present as medical problems" (Participant A).*

For this participant, the source of his headaches was stress or worry. As a new immigrant, the stress associated with gaining entry into a graduate program that would enable him to secure a decent job, support his family, and become a breadwinner as defined by his cultural norms. For him, the lack of a proper diagnosis that dug deeper to the root cause, led to lack of referral to more appropriate professionals. Therefore, according to this participant, *"[t]his complicates the referral system."* What is important, according to one participant, is for agencies to "understand the needs of refugee and immigrant mental health issues." With this understanding comes a good grasp of how to relate the needs to appropriate services, and thereby make efficient and timely referrals.

VIII. Discussion and Recommendations

The ability of newcomers to thrive in Canadian society rests on how well the settlement and integration sector can support their mental health needs. This report provides evidence to guide decision-making, and improve program and service planning for mental health, both preventative and reactive. The intent is to allow policy makers to allocate funding and design programs with a client-focus to support refugee arrivals in Alberta.

Cultural Competence: Professional Training and Professional Development

For some providers, one key recommendation to deal with lack of cultural competence among service providers, those providing health and health-related services, is to introduce cultural competence and sensitivity into the curriculum of training schools, as well as making the training available as a professional development option "to create knowledge and awareness..." of experiences of newcomers to Canada.

One participant working for the Ministry of Health suggested:

> *Staff providing the services should be appropriately trained to meet the needs of newcomers, including their cultural needs (Participant K).*

Another participant from an immigrant-serving agency recommends collaborating with agencies to "...work towards recruiting counsellors who speak other languages" (Participant L).

A complementary recommendation from another participant implies that, failing to hire staff who can speak service users' language(s) can be substituted by a resource that only AHS has access to:

> *Language line to all agencies so they can have access anytime they need to contact clients (Participant M).*

Diversity and Inclusion

This challenge is also related to the lack of knowledge of the nature and extent of trauma most clients (i.e., refugees) went through before arriving in Canada. Individuals may express psychological distress in different ways depending on their pre-migration experiences. Stressors that cause mental health problems and are considered traumatic may be different for different people.

A strategy suggested by some participants is to "...Ensure diversity of staff ...need[s] someone with the right background..." as one put it, because "[T]here is cultural incompetence and general incompetence to deal with the problem of mental health," affecting refugees and immigrants (Participant A). According to some participants, ensuring diversity in hiring meant recruitment of service providers who have training, experiential knowledge, and experience from the source country of those newcomers requiring service.

Community Participation

Establishing contact with the community is crucial to settlement, since these contacts may set the pattern for the evolution of the relationship among the newcomers, community agency partners, and the Albertan community. Host communities and local authorities can be important sources of support, since they might have already established programs and services in their communities. One participant felt that immigrant-serving agencies should dedicate more efforts to get input from the communities they work with regarding needs and expectations. Others argued that getting to know the needs of refugees and immigrants enhances the cultural competence of providers and facilitates the execution of more appropriate referrals.

Improved Screening/Diagnosis of Mental Health Issues

Some participants advised that better methods be used to screen newcomers upon or prior to arrival in order to identify those with mental health needs. This would ensure that mental health conditions do not go undetected and/or become worse during settlement.

Enhancing Accessibility

There was unanimous agreement that mental health services need to be fully accessible to refugees and immigrants. One key aspect of increasing accessibility involves making more qualified professionals available in the agencies . Also, availability of service providers and/or interpreters who can speak the language of the newcomer groups would go a long way in enhancing accessibility. According to some participants, making referrals because of lack of professionals within the agency reduces accessibility:

> *The current model of mental health services, which relies on referrals of clients with mental health concerns to other agencies has been in place for so long and it hasn't helped much; it needs to change* (Participant D).

Cultural sensitivity and appropriateness in the delivery of services is also key to making mental health services accessible and acceptable, as noted by the majority of agency representatives. Also, making newcomers easily able to access information on available services is crucial to increasing accessibility, as is timely and appropriate referrals. Accessibility can also be increased by implementing educational strategies that tackle the issue of stigma, and these would need to be implemented by people that come from the same cultural background to avoid the implication of paternalism.

Access can also be enhanced by:

> *Educating clients...providing orientation to government assisted refugees about trauma...[and] tailoring the education to country of origin and culture* (Participant L).

Holistic Focus

Several providers suggested a shift in service provision to one that is holistic, based on a holistic approach to mental health. According to one participant, holistic service could mean avoiding to provide service solely focused on mental health. A suggestion posed was a lifespan multigenerational approach that has services from the early ages of early learning. This is in concordance with the lifespan approach/model advocated by the WHO. The participant went on to say:

> *It could be that parents are dealing with things like domestic violence, inter-generational issues; or it could be that parents or youth are dealing with problems of unemployment...[because]...so many things play into mental health and mental well-being. So mental health should be embedded in other programs and services...[because] getting resources for mental health alone is not the solution... We need to revisit the existing refugee and newcomer settlement model to get to a model that approaches mental health from a holistic perspective* (Participant D).

In other words, participants are overwhelmingly suggesting that adequate attention should be paid to the social determinants of health that bring about instability of mental health. Moreover, a holistic approach implicitly entails preventative measures/interventions that promote overall well-being, and thereby prevent people from going downstream where they end up with mental health problems:

> *It is important to understand different ways to talk about mental health. Mental health should focus on wellness and overall health and well-being, including social well-being* (Participant I).

Another reason why this approach makes sense is that, for immigrants and refugees struggling to settle in a new country, mental health might not seem a priority because:

> *People focus on getting basic needs, employment, housing...involvement in sporting activities...mental health is not considered a priority* (Participant H).

Improved Collaboration

The need for collaboration among immigrant-serving organizations was strongly suggested, given the overall scarcity of resources in this sector. This would ensure greater access to those resources for those who need them. One participant suggested collaborating with faith ministries in the community by saying:

> *...Engage[ment of] other forms of supports such as the faith community, is a huge asset...It is important to equip the faith communities on how to deal with mental health issues as most people turn to them for supports. Faith communities are already set up as supportive communities- collaborate with them* (Participant G).

This assertion is echoed by another organization participant who came to Canada as a refugee and went through a stressful personal crisis, an 'issue' they were only comfortable bringing to their local church for support and resolution.

One good start to better collaboration among service providers is communication:

> *[C]ommunication between various healthcare giver organizations to create awareness among themselves about the existence of service, that would be helpful* (Participant J).

This type of communication would also enable agencies to better inform clients, and help those that seek appropriate services available in the province. The result would enable newcomers to navigate through the system of providers more efficiently:

> *I think the problem we need to address is linking community with resources in AHS, family doctors, primary health care clinics, recreational services, civil services, you name it* (Participant J).

> *It would be a good thing if systems are in place that target newcomers so that they don't have to face difficulties in seeking mental health services, but are able to access mental health services without much hassle* (Participant K).

Apart from communication, the coordination/collaboration among providers, ideal for efficient utilization of organizational resources, is improved by establishing and strengthening networks. Therefore, to avoid working in silos, this participant suggested:

> *I feel that community service agencies work more in isolation. And then they struggle, because they have no network to refer people to...That is why we need a network of people around us to assist us* (Participant J).

Closely aligned to the recommendation for better coordinated services is that of improving the integration of services. While this can also be applied to the above, with respect to integrating services among all providers of mental health services to enhance referral and accessibility, the participant who recommended this wanted to see all government services integrated so that there is seamless service for users:

> *Improvements needed are integrated health service delivery such that if a refugee, newcomer or immigrant comes and knocks at [the] government's door, the services are there and are provided on time. Also, the government needs to work to make sure that the services are of high quality, delivered on time* (Participant K).

Also key to this suggestion is the insistence on timeliness of services, it echoes the concern about wait times mentioned earlier in the report.

Utilize Peer Leaders/Mentors in the Community

In varying ways, several participants noted the need to work with community members from the same cultural background as the refugees and immigrants that agencies are serving. This untapped resource can be trained to work to promote health and well-being in their communities. They, for example "...can deal with domestic violence issues in a way that is safe for them and safe for the people they want to help" (Participant H). A related

recommendation is that of "us[ing] natural [community] supports as interpreters" because they already have a relationship with the clients (Participant H).

Funding

While most organization representatives spoke of a need for an increase in financial resources for the agencies, one focused on funding for grassroots preventative strategies. Another says: "More funding for mental health- to non-profits to assist war victims" (Participant M).

XI. Next Steps

There are very complex issues involving mental health in Alberta. A more in-depth study using larger samples sizes would yield more generalizable results and further insights. The findings would be generalizable to other regions not covered by individual and organization interviews, and would provide a robust framework for policy makers and guidelines for service providers.

There are very complex issues involving accessing mental health services in Alberta. Strategies for improving services can be developed in consultation with groups such as Alberta Health Services, settlement agencies, and other stakeholders. A comprehensive training program for professional and para-professionals focussing on cultural competency, would complement these efforts.

Improving the system requires both financial and human resources. While there is evidence of large government investment the study reports gaps. There is a correlation between better access to mental health services and cost savings when clients require treatment for more complex conditions that develop in the absence of early intervention.

A longer and more in-depth study using bigger samples sizes and focussing on pathways for refugees and immigrants would yield further insights. The findings would be a robust framework for policy makers and guidelines for service providers.

X. Glossary of Terms

Asylum Seeker is a person who has left their home country as a political refugee and is seeking asylum in another country such as Canada.

Capacity is defined as the ability of an organization or system to fulfill its goals. Capacity can be expressed in terms of its human, physical and material resources, financial, information, and intellectual resources.

Children and Youth Services seek to support the settlement and integration outcomes of children, youth and their families. Examples of programs include: academic support, afterschool programming, mentoring, child care, childhood development, family services, outreach and settlement in school.

Community Services are aimed at building social capital for newcomers, facilitating connections between newcomers and public services and structures, and contribute to strengthening municipalities as welcoming communities for newcomers. Initiatives such as LIPs are included within this stream.

Cultural Competency requires that organizations have a defined set of ethics and principles, and demonstrate behaviors, attitudes, policies, and structures that enable them to work effectively cross-culturally.

Environmental Scan is a process that systematically surveys programs and services, and interprets relevant data to identify external needs and opportunities

Government Assisted Refugees (GARs) are Convention Refugees Abroad whose initial resettlement in Canada is entirely supported by the Government of Canada or Quebec. This support is delivered by Immigration, Refugees and Citizenship Canada (IRCC) supported non-governmental agencies such as CCIS, CSS, SAAMIS Immigration Services Association, and Lethbridge Family Services-Immigrant Services, in Alberta. Support can last up to one year from the date of arrival in Canada, or until the refugee is able to support himself or herself, whichever happens first. This support may include: accommodation, clothing, food, employment, and other resettlement assistance.

Health Services provide counselling, health literacy, mental and physical health, and provisions for disabilities. Examples include: crisis counselling, sexual health, and health clinics.

Integrated Services Program (ISP) is a partnership between Immigration, Refugees and Citizenship Canada (IRCC), and Alberta Labour to support community-based programs and services that assist newcomers to settle and integrate in Alberta. ISP coordinates the funding and accountability processes for contracted, community-based, and non-profit organizations to provide services and activities that increase newcomers' ability to access information, services and resources, and enhance their labour market participation and economic independence. ISP programs are available to government-assisted refugees and privately-sponsored refugees.

Language Services provide language and literacy assessment and training in official languages for settlement, education, and employment purposes. Examples of programs include: ESL Programs, Language Instruction for Newcomers to Canada (LINC), Learning support services, conversation cafes, and home instruction.

Mental Health is related to mental and psychological well-being.

Mental Illness relates to any disturbance to one's mental well-being, which can lead to diminished functioning of the individual. Such changes can be mild (example stress) or extreme (depression and schizophrenia).

Needs Assessment (in the system of care) forms part of a systematic process to determine and address the needs or gaps between a client's current conditions and the desired conditions or outcomes in the settlement service continuum of care.

Para-professionals refers to a person to whom a particular aspect of a professional task is delegated but who is not licensed to practice as a fully qualified professional.

Privately Sponsored Refugees (PSRs) are refugees and persons that meet the definition of one of the refugee classes: the Convention Refugee Abroad Class and/or the Country of Asylum Class as defined by

Canada's Immigration and Refugee Protection Act. Through the Private Sponsorship of Refugees Program, Canadian citizens and permanent residents help settle PSRs from abroad in Canada. In most cases, PSRs receive financial help from their sponsor, not the government. PSRs are eligible to access the same settlement support services as other permanent residents.

Psycho-Social Therapy include structured counselling, motivational enhancement, case management, care-coordination, psychotherapy and relapse prevention.

Refugee Claimants are refugees who have fled their country and are asking for protection in another country. A refugee claimant receives Canada's protection when found to be a Convention Refugee, or when found to be a person needing protection based on risk to life, risk of cruel and unusual treatment or punishment, or in danger of torture as defined in the Convention Against Torture. 'Claimant' is the term used in Canadian Law.

Service Areas Information and Orientation as well as client Needs Assessment are common offerings within each service area.

Social Isolation is a state of complete or near-complete lack of contact between an individual and society. It differs from loneliness, which reflects a temporary lack of contact with other humans.

Support Services are provisions and resources, transportation, legal services, and financial services provided to newcomers. Examples of program offerings include: clothing and food, computer labs, low income support for transit, financial literacy, tax clinics, grants, loans.

Trauma is a response to a terrible event like an accident, rape, or natural disaster. Long term reactions may include unpredictable emotions, flashbacks, strained relationships, and even physical symptoms like headaches or nausea.

Vulnerable Groups refer to individuals or groups of individuals who are made vulnerable by the situations and environments that they are exposed to (as opposed to any inherent weakness of lack of capacity).

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